CHAPTER 1

The Health Care Reform Legislation: An Overview

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THE AFFORDABLE CARE ACT (ACA) represents the most significant overhaul of our health care system since the establishment of Medicare and Medicaid. The ACA does two things: First, it fundamentally shifts the social contract in the United States. Starting in 2014, individuals will be required to have health insurance; in return, the federal government will significantly expand low-income health insurance subsidies. Second, it significantly rebalances the financing for Medicare by reducing the growth in outlays and increasing Medicare taxes paid by high earners.

This chapter provides non-specialists with a guide to the major provisions, their logic, and the federal budgetary implications. (All revenue and spending figures that follow refer to 10-year totals for

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FY 2010 to 2019 and are based on CBO and Joint Tax Committee estimates.)

MEDICARE

The ACA reduces Medicare outlays by roughly $400 billion. Two-thirds of this comes from reduced growth in the payment rates that medical providers receive in the traditional fee-for-service program (see Table 1.1). Most of the rest comes from reductions in premiums paid to privately managed care plans. The payment rate reductions—roughly one percentage point a year—apply broadly to most types of medical services, except for physicians (who have no reductions) and home health care agencies (which face disproportionately large cuts).

On the revenue side, the ACA raises Medicare hospital insurance (HI) taxes by over $200 billion. Starting in 2013, earnings above a cutoff ($200,000 for singles; $250,000 for couples) will be subject to an additional 0.9 percent tax, on top of the current 2.9 percent. Also starting in 2013, high-earning families will pay a new 3.8 percent HI tax on net investment income (interest, dividends, rents, and taxable capital gains). The ACA also raises the premiums that high-income Medicare beneficiaries will pay for physician and prescription drug coverage and reduces federal subsidies to hospitals that disproportionately serve low-income patients (DSH). Also, deductibles and coinsurance in Medicare Part D prescription drug plans (the "donut hole") will shrink over the next decade, due to a combination of manufacturer discounts and additional federal financing.

The combination of reduced outlays and increased revenues substantially improves Medicare's fiscal picture and pushes the Part A insolvency date—the year in which the Medicare Trustees project that the HI trust fund will be exhausted—from 2017 to 2029. The reduction in premiums paid to Medicare Advantage will likely lead those plans to raise premiums or cut benefits, which will cause some

TABLE 1.1
Summary of the Major Provisions in the ACA

	Effect on Federal Deficit (2010–19, $ billions)
Medicare Provisions	
Reduced provider payment rates	–230
Reduced premiums to private plans	–140
Increased premiums for high-income beneficiaries	–40
Close "donut hole"	40
New HI tax on high earners	–210
Miscellaneous (DSH, IPAB, CMI, ACOs, bundling, etc.)	–50
Net, Medicare Provisions	*–610*
Coverage and Revenue Provisions	
Medicaid expansion	430
Exchange credits	460
Small business credit	40
Tax on health insurers and manufacturers	–110
Penalties on firms and individuals	–70
Limit deductibility of health care expenses	–30
Nonhealth revenue provisions	–50
High-premium excise tax	–20
Reduce Medicaid Rx prices	–40
Miscellaneous (administrative simplification, high-risk pool, early retirees, etc.)	–30
Net, Coverage and Revenue Provisions	*590*

Note: This table excludes the off-budget effects of the ACA on the Social Security program and excludes the CLASS act and the education provisions in the ACA.

beneficiaries to shift out of those plans and back to the fee-for-service program.

Rhetoric claiming that the ACA will accomplish more fundamental Medicare reform is generally overblown. For example, the new Independent Payment Advisory Board (IPAB) has been touted as the ACA's "most important institutional change." The concept was to delegate to a body outside Congress the authority to make fiscally sound, but unpopular, changes to Medicare. But IPAB is highly constrained

in its design. Its reforms are limited in nature (no rationing, no restricting benefits); in scope (hospitals and most other providers are off-limits until 2019); and in timing (IPAB can only make reforms if projected Medicare-spending growth exceeds a target growth rate). Crucially, IPAB's target growth rate—GDP per capita plus one percentage point—is unsustainably high, which essentially ensures that IPAB will not solve Medicare's long-term financing problem.

Three other Medicare provisions have also received outsized attention:

- *Center for Medicare and Medicaid Innovation (CMI).* The ACA expands the executive branch's authority to conduct "demonstrations" testing alternative payment and delivery systems in Medicare and Medicaid. How the CMI will play out is highly uncertain. The CBO projected that it would have essentially no impact on spending.
- *Accountable care organizations (ACOs).* The concept behind ACOs is to encourage medical providers to form integrated systems and to incentivize those systems to reduce utilization while meeting quality benchmarks. But under the ACA, provider participation is purely voluntary, and incentives are one-sided: bonuses are available for ACOs that come in below a spending target, but there is no penalty for overshooting. Some ACOs will likely end up earning windfall bonuses due to the natural variability in health spending. The CBO guessed that, on the whole, ACOs would very modestly reduce Medicare spending, but those windfalls could very easily end up increasing it instead.
- *Bundling.* Paying medical providers for a broadly defined "bundle" of services (rather than by individual service) holds great promise for reining in cost growth. The ACA includes a bundling provision but only creates a limited pilot program for payments for hospital and post-acute care.

COVERAGE

The ACA's core coverage goals were (1) to ensure that everyone, regardless of health status or income, has adequate access to health insurance and health care; and (2) to minimize disruptions to the current system. The ACA's coverage provisions have four interdependent components: (1) subsidies for low-income individuals; (2) an individual mandate; (3) a prohibition on insurers' denying coverage or varying premiums on the basis of health status; and (4) the definition of a minimum health insurance package. Without the subsidies, health care is unaffordable for those with low incomes. Without the mandate, healthier individuals opt out of the market, possibly leading to collapse. Without the limits on insurers, market pressures force them to charge higher premiums to individuals in poor health status or deny them coverage altogether. The defined minimum benefit package is necessary to determine whether individuals have satisfied the mandate and whether they have enrolled in coverage that is eligible for the new subsidies.

Subsidies. Medicaid—which provides health care coverage with no premiums and very low or no cost sharing—has historically only been available to children in very low-income families, and their parents. Starting in 2014, the ACA will expand eligibility to every person below 138 percent of the federal poverty level (FPL) including, most importantly, adults without young children. This expansion is, in my judgment, the largest single component of the ACA. It accounts for roughly half of gross coverage costs. By 2019, it will shift roughly 16 million people into Medicaid (a number nearly as large as the number of elderly persons who enrolled in Medicare when it was first launched). For the non-elderly and non-disabled, the ACA standardizes the income-counting rules used for determining Medicaid eligibility and eliminates asset tests. Additional provisions streamline and simplify enrollment in Medicaid.

Beginning in 2014, the ACA will offer a refundable tax credit for the purchase of health insurance through newly established health insurance markets ("exchanges"). These credits (discussed in the chapter in this book by Duggan and Kocher) account for the bulk of the remainder of gross coverage costs. The ACA also includes an employer tax credit that can offset up to half of employer contributions for health insurance, but only for very small firms with low-wage workers. This credit, compared to other aspects of the ACA, is small and has relatively little impact on coverage.

Individual mandate. Also beginning in 2014, the ACA will require almost everyone in the United States to enroll in health insurance. Once fully phased in, the penalty for not doing so will equal the greater of a flat dollar amount ($695 per uninsured adult) and 2.5 percent of family income. Groups exempt from the penalty include families with income below the income-tax-filing threshold; American Indians; and families for whom the cost of coverage would be unaffordable (defined as exceeding 8 percent of income) or would result in hardship (to be defined later). The IRS will monitor compliance and assess penalties through the tax system.

Limits on insurers. In most states, health insurers in the individual market have been permitted to choose whether to offer coverage based on an individual's health history; exclude coverage for "preexisting" (i.e., already diagnosed) medical conditions; vary premiums on the basis of health status; and rescind coverage if the insurer uncovers "misstatements" (whether intentional or not) on the enrollee's application. Under the ACA, starting in 2014, all four of those practices will be prohibited in the individual insurance market. The ACA also places new restrictions on insurers in the small-employer and large-employer markets, but those restrictions are generally not binding.

Minimum coverage. The ACA defines three rings of insurance coverage: The outermost ring consists of all coverage satisfying the individual mandate. (This includes everything we would deem "real" health

insurance: Medicare counts, but not, say, vision only.) The second, smaller ring consists of all small-group and individual coverage. Starting in 2014, these plans must provide "essential health benefits," which will include coverage of a broad set of services (hospital, prescription drugs, etc.), and must choose a cost-sharing design that fits into one of five actuarial value tiers ("platinum," "gold," etc.). The innermost ring consists of "qualified health plans": plans offered through the new exchanges and potentially eligible for exchange credits. These plans must be certified by the exchanges as meeting additional criteria relating to plan quality, marketing, and value.

REVENUES

To offset the cost of its subsidies, the ACA raises federal revenues from various sources, mostly within the health care system. These revenues include: broad-based taxes on health insurers and makers of brand-name prescription drugs and medical devices; penalties on large employers that do not offer affordable health coverage and on uninsured individuals; limits on the deductibility of medical expenses for individuals and firms; and some miscellaneous non-health revenue provisions (e.g., an excise tax on indoor tanning). The ACA also includes several provisions that reduce federal outlays and thereby offset some of the coverage costs, such as a reduction in the prices that Medicaid will pay for prescription drugs.

MARKETS

Several major components of the ACA attempt to correct perceived market distortions, create new markets, or improve the functioning of existing markets. Besides exchanges, discussed in the chapter by Duggan and Kocher, these changes include:

- *Limiting the tax subsidy for employer-sponsored coverage.* The tax treatment of employer-sponsored health benefits—that is, deductibility for the employer and exclusion from taxable income for the employee—has long drawn fire from economists, most notably Martin Feldstein, for putting upward pressure on health care costs. The ACA takes a small step in the direction of limiting that tax subsidy. Beginning in 2018, insurers and self-insured employers will be subject to an excise tax on employer-sponsored health benefits in excess of a ceiling. The ceiling will be at least $10,200 for single plans and $27,500 for family plans in 2018—higher if premiums grow faster than expected, if an employer's workforce is unusually old, or if the enrollee is a retiree or a worker in a high-risk profession. The ceiling, which is indexed to the Consumer Price Index-All Urban Consumers (CPI-U), will likely grow more slowly than premiums, which means that its impact is projected to grow gradually.
- *A new long-term-care insurance product.* The private market for long-term-care insurance has never really gotten off the ground due, at least in part, to the inherent instability in private insurance contracts spanning many years or decades. The ACA establishes the Community Living Assistance Services and Supports (CLASS) program, which was designed to be a voluntary, community-rated long-term-care insurance product administered by the federal government and fully funded by enrollee premiums. (In late 2011, the Administration determined that the CLASS program could not be implemented in a financially sustainable way, and the program has been discontinued.)
- *Administrative simplification.* The ACA broadens the scope of federal regulations governing interactions among health insurers and providers (e.g., submission of claims for payment, eligibility verification). The CBO judged that the resulting

reduction in premiums would be "modest" in percentage terms, but the base over which those savings accrue—almost the whole of health spending in the United States—is enormous.

- *Minimum loss ratios (MLRs).* The ACA requires, as of 2011, that health insurers spend at least a minimum percentage of their premium revenues on medical claims (i.e., losses) or quality-improvement activities. That minimum equals 80 percent in the individual and small-group markets and 85 percent in the large-group market. In the individual market, many insurers currently have loss ratios well below this cutoff, which means that their current business model and cost structure are no longer viable. It remains to be seen whether MLRs will improve the individual market or seriously disrupt it.

(The ACA contains numerous other provisions, most relating to quality improvement, public health, home-based services, and the health care workforce. They include expanded federal funding for community health centers, state-run high-risk pools, and health benefits for early retirees. They are mentioned here only in passing, as they are relatively unimportant fiscally and unrelated to the core coverage provisions.)

CONCLUSIONS

Historically, the pattern has been for the Medicare program's fiscal condition to deteriorate until—with insolvency looming—Congress temporarily rights the ship by reducing outlays and raising revenues. The ACA fits squarely in that tradition, but with a major twist: all of the Medicare savings and new revenues were spent on a major coverage expansion. The result is that Congress soon will be looking

either for more Medicare savings or revenues, or for other ways to offset the cost of the coverage expansion. Either way, the policy focus will almost certainly shift rapidly from coverage to health care cost containment.

REFERENCES AND FURTHER READING

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